CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, Medicaid may restrict or terminate the provider's participation in the program.

CERTIFICATION AND RECERTIFICATION

Introduction

The Medical Assistance Program recognizes the physician as the key figure in determining utilization of health services; the physician determines the appropriateness of admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. In recognition of this responsibility, Medicaid calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Medicaid requires that payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished and, in certain instances, only if there is a physician's recertification as to the continued need for the covered services. The certification must be in writing and must be signed by an individual clearly identified as an M.D. or a D.O. Certification must be dated at the time it is signed.

The provider of services is responsible for obtaining the required physician certification and recertification statements and for retaining them on file for verification, when needed by the intermediary or by this state agency.

Each provider of services determines the method by which the required physician certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, so long as the approach adopted by the provider permits verification that the requirement of physician certification and recertification, set forth in this part, is met. Certification and recertification statements may be entered on or included in forms, notes, or other records a physician normally signs in caring for a patient, or a separate form may be used. Each certification and recertification statement is to be separately signed by a physician, except as otherwise specified in this part.

The requirements for recertification (and for certification for inpatient hospital services furnished), set forth in this part, specify certain information that is to be included in the physician's statement. It should be noted that this required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate where the required information is contained in the patient's medical record.

Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored if, for example, the patient was unaware of his or her eligibility for Medicaid benefits when he or she was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant for explaining the delay. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Admission Certification and Plan of Care

Federal regulations mandate that there must be an admission certification and plan of care for every Medicaid inpatient hospital admission (see "Exhibits" at the end of this chapter for a sample of this form). Compliance is monitored on a regular basis by Medicaid's utilization review staff. Noncompliance may result in reimbursement being recouped by Medicaid.

Admission

42 CFR § 456.60 requires a physician certification that inpatient hospital services are necessary for each hospitalized recipient. A physician must certify the need for inpatient care **at the time of admission**. The certification must be in writing and signed by an individual clearly identified as a physician (M.D.), doctor of osteopathy (D.O.), or dentist (D.D.S.). **The certification must be dated at the time it is signed.**

The certification may be: A) a separate form to be included with the patient's records, B) an **identifiable** part of the physician's orders, history, and physical or other **identified** locations within the patient record, or C) a stamp with the statement. The words "Certified for Hospital Admission" must be contained within the certification. This certification must be signed and dated by the physician at the time of admission, or, if an individual applies for assistance while in the hospital, before payment is to be made by DMAS.

For all inpatient services, the practitioner's documentation must justify the medical need for inpatient hospital services at the time of admission. Physician admission orders, a medical history, physical examination, presumptive diagnosis, and a detailed plan of care must be completed on the day of admission. These items must be retained by the hospital for review as Medicaid deems necessary.

Recertification

A physician acting within the scope of practice as defined by state law must recertify for each patient that inpatient services in a hospital are needed. Recertification must be made at least every 60 days after certification.

Plan of Care

42 CFR § 456.80 requires that a written plan of care be established at the time of admission or before DMAS or other DMAS representatives can authorize payment for care for each recipient. The plan must be an **identifiable** part of patient records, and Virginia Medicaid requires that the plan include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;

- Any orders for medication, treatment, restorative or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate;
- Estimated length of stay; and
- Tentative discharge plan.

An admission certification and plan of care form similar to the sample admission certification and plan of care in the "Exhibits" section is preferred in order to meet federal requirements in a uniform manner. Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to the above stated policies.

Certification and Recertification for Recipient Receiving Retroactive Eligibility

If any individual receives services before his or her entitlement to Medical Assistance Program benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. Example: If any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission.

UTILIZATION REVIEW ACTIVITIES

Introduction

In addition to the certification and recertification by the patient's own physician, the hospital is required to have a utilization review plan which provides for review of **all** Medicaid patient stays and medical care evaluation studies of admissions, durations of stay, and professional services rendered. The objective of the utilization review mechanism is the maintenance of high-quality patient care and the most efficient utilization of resources through an educational approach involving the study of patient care.

The objective of utilization review is to ensure that inpatient care is provided only when medically necessary and that the care meets quality standards.

Medicaid requires that effective utilization review be maintained on a continuing basis to ensure the medical necessity of the services for which Medicaid pays and to promote the most efficient use of available health facilities and services.

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Admission Review

The Virginia Medical Assistance Program delegates utilization review of inpatient hospital services for all Medicaid admissions to the local facilities' utilization review department. Medicaid requires 100 percent utilization review of Medicaid patients. The hospital must have a utilization review plan (42 CFR §§ 456.101 - 456.145) reflecting 100 percent review of Medicaid patients, approved by the Division of Licensing Certification, Department of Health (VDH), and DMAS or appropriate licensing agency in the state in which the institution is licensed. Staff will review the functions associated with approved hospital utilization review plans for compliance with 42 CFR §§ 456.101 to 456.145.

The hospital utilization review coordinator is required to approve the medical necessity, based on a list of admission criteria approved by the Utilization Review Committee, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the very next working day. This must be reflected in the hospital utilization review plan and the patient's record.

- If the admission is determined to be medically necessary, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances that are properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a Utilization Review Committee in one facility is not binding upon the Utilization Review Committee in another facility.

- If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and be allowed to present additional information. If the hospital physician advisor still finds the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. Copies of this decision must be sent by the Utilization Review Committee's designated agent to the hospital administrator, attending physician, recipient or recipient's authorized representative, and Medicaid. Medicaid notification must be sent to:

  Manager, Payment Processing Unit
  Division of Program Operations
  Department of Medical Assistance Services
  600 East Broad Street, Suite 1300
  Richmond, Virginia 23219

The role of the hospital Utilization Review Committee is to ensure that only medically necessary care is delivered. The hospital Utilization Review Committee must issue a written adverse determination letter to the recipient if, after following the regulatory steps of adverse determination, the Committee determines that the admission or continued stay is

not medically necessary. For general hospitals, refer to 42 CFR §§ 456.121 to 456.126 and §§ 456.131 through 456.137. For mental hospitals, refer to 42 CFR §§ 456.236 through 456.238. These citations describe the review procedures required, including the adverse determination steps.

When communicating an adverse determination decision to a recipient, the hospital must clearly indicate, in a letter to the recipient, that the decision is based on the medical necessity review of the Utilization Review Committee at the hospital. Further, the adverse determination letter must indicate that the attending physician has been notified of the decision and must advise the recipient that he or she will be responsible for payment after the effective date of the adverse determination. The letter must be signed by a representative of the hospital's Utilization Review Committee and by the recipient as an acknowledgment of the receipt of the notification.

There has been no modification to the hospital adverse determination process as the result of the hospital preauthorization process performed for DMAS by WVMI (see Chapter IV). DMAS will not acknowledge adverse determination letters issued by hospitals unless they follow the guidelines detailed in this manual and in the Code of Federal Regulations. Further, hospitals may not hold any Medicaid recipient liable for any portion of the hospital bill unless the hospital Utilization Review Committee has communicated to the recipient its adverse decision based on medical necessity. The only exception to this would be for a non-Medicaid-covered service and the applicable copayments.

The hospital Utilization Review Committee's decision should in no way be confused with a preauthorization review decision rendered by WVMI. Hospitals may not rely on the WVMI decision either to justify or deny an admission to or continued stay in the hospital. The responsibilities of the hospital Utilization Review Committee are independent of the authorization performed by WVMI.

Medical Care Evaluation Studies (MCEs)

As part of their utilization review plan, hospitals must have one medical or patient care evaluation study in process and one completed each calendar year. Medical care evaluation studies must contain the elements mandated by 42 CFR §§ 456.141 through 456.145. Virginia Medicaid requires that each study must include:

- Objectives of the study;
- Results of the study;
- Evaluation of results; and
- Action plan or recommendations as indicated by study results.

Length-Of-Stay Monitoring Activity
[Effective Date: For Dates of Service on and after July 1, 1991 and before each hospital's activation of the preauthorization process]

The Medicaid Program will monitor the length of stay for inpatient hospital stays. The guidelines used will be based on 1999 (ICD-9-CM) diagnosis code data prepared by HCIA, Inc., in the *Length of Stay by Diagnosis and Operation, Southern Region, 1994*. Claims with lengths of stay less than eight (8) days but exceeding the assigned percentile length-of-stay must be accompanied by a copy of the discharge summary, history and physical, and relevant patient progress notes. These claims will pend for review and appear under "pending" on the remittance voucher. The message on the remittance voucher will read "The length of stay exceeds the percentile limit" or "7-day limitation exceeded." A prepayment review of this documentation will focus on the necessity of admission and continued stay, discharge planning, and other Medicaid requirements. If the stay or portion of it is found to be medically unnecessary, contrary to Medicaid requirements, or if the required documentation has not been received, reimbursement will not be made by DMAS.

Hospital claims will be pended and reviewed to determine each individual hospital's utilization review performance based on the denial rate of the total pended days.

Percentile Review Edit Status

Hospitals with an eleven percent (11%) or more denial rate will be placed on the 75th percentile length of stay edit for manual documentation review.

Hospitals with a 4.1 percent to 10.9 percent denial rate will be placed on the 90th percentile length of stay edit for manual documentation review.

Hospitals with a four percent (4%) or less denial rate will be placed on the 95th percentile length of stay edit for manual documentation review.

A hospital's percentile will determine the extent to which claims are pended for the length of stay edit. However, all other utilization review edits will continue to be applied.

Exemption Pend Edit Status
[Effective July 1, 1991]

Hospitals which have maintained the 95th percentile review of documentation edit for two consecutive years and a three percent (3%) or less (but more than a one percent [1%]) denial rate will have the documentation requirements exempted for the following pend edits:

Fourteen/Seven Day Limitation Exceeded (218);
Review Admission Date/First Surgical Date (254);
Review Friday/Saturday Admission (255); and
Length of Stay Exceeds Percentage Limit (257).

Delegated Review Status
[Effective November 1, 1990]

Hospitals which have maintained the 95th percentile review of documentation edit for two consecutive years with a one percent (1%) or less denial rate will have the documentation requirements exempted for the following pend edits:

Fourteen/Seven Day Limitation Exceeded (218); [Effective 7-1-91]
Pending Review of Services (220);
Review Admission Date/First Surgical Date (254);
Review Friday/Saturday Admission (255);
Length of Stay Exceeds Percentage Limit (257);
Review Outpatient Surgery (269)
Pend Review EPSDT Service (280); and
21/60/21 Hospital Medical Review (281).

Delegated Review Status Audit Compliance Conditions
[Effective November 1, 1990]

The following audit conditions will apply to hospitals that have been placed on delegated review status:

a. DMAS will conduct periodic onsite or desk post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

b. The hospital will make all medical records requiring medical review available upon request, and will provide an appropriate place for DMAS auditors to conduct such reviews.

c. The qualifying hospital will immediately refund to DMAS in accordance with § 32.1-325.1 of the Code of Virginia the full amount of any initial adverse overpayment decisions pursuant to the current administrative process for post-payment appeals.

d. DMAS, at its option, depending upon the utilization review performance determined by an audit based on the criteria previously set forth in this chapter, may remove a provider from delegated review status and may reapply certain or all prepayment utilization documentation requirements.

A statistical random selection of non-pended claims will be reviewed on the hospital on-site survey for those hospitals that have been exempted from certain pend edits and documentation requirements. The total approved days versus the total reviewed days will be tallied to determine the utilization review compliance and performance in applying the appropriate utilization review edit level.

All edits and documentation required by federal mandate or the Virginia *State Plan for Medical Assistance* must remain in place (e.g., sterilization, hysterectomy, and abortion certification forms) and must be reviewed.

ABORTIONS

Induced or elective abortions are covered by the Virginia Medical Assistance Program upon the physician's certification that in his or her professional medical judgment the health or life of the recipient would be substantially endangered if the fetus were carried to term and that such judgment shall be exercised in light of all factors - physical, emotional, psychological, familial, and the woman's age - relevant to the well-being of the patient.

The policy statement does not pertain to the treatment of incomplete, missed, or septic abortions. Reimbursement for these types of abortions are covered as before.

The abortion certification (DMAS-3006) must accompany each claim for an induced (elective) abortion. Note that, if a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify; however, if this is not the case, but her health would nonetheless be substantially endangered, the attending physician must certify that fact. This certification is necessary to comply with federal reporting requirements which differentiate between the degrees of medical necessity for abortions and which enable matching federal funds to be used.

A copy of the physician certification (DMAS-3006) must be attached to each invoice related to the induced abortion (e.g., surgeon, hospital, anesthesiologist). (See "Exhibits" at the end of this chapter for a sample of this of this form.) Any claim submitted without the appropriate certification will be denied. All billing providers must secure a copy of the physician certification from the originating physician.

Reimbursement is available for those abortions performed during periods of **retroactive** eligibility if the physician certifies in writing on the DMAS-3006 that, on the basis of his or her professional judgment, **the life or health of the mother would have been endangered** if the fetus had been carried to term. The certification must contain the name and address of the patient and the recipient ID number.

ICD-9-CM Abortion Procedure Codes*

6901	Dilation and curettage for termination of pregnancy
6951	Aspiration curettage of uterus for termination of pregnancy
7491	Hysterotomy to terminate pregnancy
750	Intra-amniotic injection for abortion

Excludes: Insertion of prostaglandin suppository for abortion (9649)

*Note: The codes that define abortion procedures refer to legal abortions only. These procedures must meet specific criteria to receive federal matching funds. Any medical treatment as a result of an abortion is considered a medical service and not subject to funding restrictions.

See the "Replenishment of Billing Materials" section on page 3 in Chapter 5 for information on obtaining a copy of the DMAS-3006.

HYSTERECTOMY

According to federal regulations, hysterectomy is not a sterilization procedure. Therefore, patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization consent form (DMAS-3004) or adhere to the required waiting period. However, hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid.

Conditions for Service

Payment may be made for hysterectomies as follows:

- **Medically Necessary** - A medically necessary hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has informed the individual or her representative, if applicable, orally and in writing **before the surgery** is performed that the hysterectomy will render the individual permanently incapable of reproducing, and the individual or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form (DMAS-3005). (See "Exhibits" at the end of this chapter for a sample of this form.) The Physician Statement must be completed and signed by the physician, and in this situation, Section A must be marked.

  When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form is also required. Therefore, it is advisable to inform the patient or her representative prior to the exploratory surgery or biopsy. Again, Section A of the Physician Statement must be completed.

- **Emergency** - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances, Section B of the Physician Statement must be marked and a description of the nature of the emergency must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form. An example of this situation would be when the patient is admitted to the hospital through the emergency room for immediate medical care, and the patient is unable to understand and respond to information pertaining to the acknowledgment of the receipt of hysterectomy information due to the emergency nature of the admission.

- **Sterility** - If the patient is sterile prior to the hysterectomy, Section C of the Physician Statement must be marked and a statement regarding the cause of the sterility must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form. (For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.)

Claims Requirements

A copy of the form DMAS-3005 must be attached to each provider's invoice for a hysterectomy procedure if Medicaid is to consider the claim for payment. Failure to provide the appropriate acknowledgment or certification will result in denial of the claim. Hospitals and other billing providers will need to secure from the originating provider a copy of the DMAS-3005 before submitting their claims to Virginia Medicaid. Any claim submitted without a properly executed DMAS-3005 or documentation showing emergency medical necessity will be denied.

ICD-9-CM Hysterectomy Procedure Codes

683	Subtotal abdominal hysterectomy
684	Total abdominal hysterectomy
685	Vaginal hysterectomy;
6851	Laparoscopically Assisted Vaginal hysterectomy (LAVH)
6859	Other Vaginal Hysterectomy
686	Radical abdominal hysterectomy
687	Radical vaginal hysterectomy
688	Pelvic evisceration
689	Other and unspecified hysterectomy
6919	Other excision or destruction of uterus and supporting structures

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Retroactive Coverage

Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician will certify on the DMAS-3005 that one of the following conditions was met:

- The physician informed the recipient before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005.

- The recipient met one of the exceptions provided in the Physician Statement Section of the DMAS-3005. In this case, no recipient signature is required.

STERILIZATION

Human Reproductive Sterilization

Human reproductive sterilization is defined by DMAS as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations that are performed because pregnancy would be life-threatening to the mother (so-called "therapeutic" sterilizations) are included in this definition. The term sterilization, as used in Medicaid regulations, means only human reproductive sterilization, as defined above.

Note: Treatment which is not for the purpose of, but results in, sterility (formerly referred to as secondary sterilization) does not require completion of the Sterilization Informed Consent Form. This applies for the purposes of Medicaid payment only. Informed consent and billing requirements associated with the performance of a hysterectomy are referred to later in this section.

Conditions of Coverage

The conditions under which sterilization procedures for both inpatient and outpatient services are payable by Medicaid conform to federal regulations.

A sterilization will be covered under Medicaid only if the following conditions are met:

- The individual is at least 21 years old at the time consent for sterilization is obtained.

  Note: A patient must be 21 years old to give consent to a sterilization. This is a federal requirement for sterilizations only (see 42 CFR § 441.253) and is not affected by any other state law regarding the ability to give consent to medical treatment generally. The age limit is an absolute requirement. There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not a mentally incompetent individual. For Medicaid purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an **absolute** requirement. There are no exceptions.

- The procedure has not been court-ordered.

- The individual has **voluntarily** given informed consent in accordance with all the requirements prescribed in this section.

- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure. This form is to be signed by the physician and witnessed.

- The individual is not institutionalized. For the purposes of Medicaid reimbursement for sterilization, an institutionalized individual is a person who is:

    - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or

    - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness

- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances:

    - Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

    - Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

- A completed consent form must accompany all claims for sterilization services. This requirement extends to all providers: attending physicians or surgeons,

assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to post-surgical complications do not require consent documentation.

Informed Consent Process of Sterilization

The informed consent process may be conducted either by a physician or by the physician's designee.

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:
  - Offered to answer any questions the individual may have had concerning the sterilization procedure;
  - Provided the individual with a copy of the consent form; and
  - Provided orally all of the following information to the individual to be sterilized:
    - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;
    - A description of available alternative methods of family planning and birth control;
    - Advice that the sterilization procedure is considered to be irreversible;
    - A thorough explanation of the specific sterilization procedure to be performed;
    - A full description of the discomforts and risks that may accompany or follow performing the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
    - A full description of the benefits or advantages that may be expected as a result of the sterilization; and
    - Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of

premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.

- Suitable arrangements were made to ensure that the information specified above was effectively communicated to any individual who is to be sterilized.
- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
- The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.
- The sterilization operation was requested without fraud, duress, or undue influence.
- All other state and local requirements were followed.
- The appropriate consent form was properly filled out and signed (see below).
- **Informed consent may not be obtained while the individual to be sterilized is**:
  - **In labor or within 24 hours postpartum or post-abortion**
  - **Seeking to obtain or obtaining an abortion**
    - "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.
    - "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

    DMAS prohibits the giving of consent to a sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.
  - **Under the influence of alcohol or other substances that affect the individual's state of awareness**

Sterilization Consent Document

The only acceptable sterilization consent form is the DMAS-3004. An informed consent does not exist unless the Department of Medical Assistance Services Consent Form (DMAS-3004) is completed voluntarily by a person 21 years of age or over and in accordance with the following requirements. (See "Exhibits" at the end of this chapter for a sample of this form.). No payment will be made without the submission of this form completed, signed, and dated by the patient giving the consent, the person obtaining the consent, and the physician who performed the surgery. The date of the signature of the person obtaining an informed consent must be the same as the date of the signature of the person giving consent. Instructions for completing the form are shown the following page. The numbered items correspond to the numbers on the form as shown under "Exhibits."

Instructions for Completing the Consent Form (DMAS-3004)

Ref. No.	Blank	Instructions
1	**Doctor or Clinic**	This line may be prestamped. If the provider is a physician group, all names may appear (e.g., Drs. Miller and Smith); the professional group name may be listed (e.g., Westside Medical Group); or the phrase "and/or his/her associates" may be used.
2	**Name of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
3	**Month, Day, Year**	Enter the patient's birth date. This information is required.
4	**Patient name**	Must be completed. The name used must be identical to the patient name appearing on the claim form.
5	**Doctor**	May be prestamped. If a group, all names may be listed, or the phrase "and/or his/her associates."
6	**Name of Operation**	Enter the name of the operation. If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation must be written out at the bottom of the form.
7	**Signature**	The patient must sign here. If the patient is illiterate, the form of signature permitted is an "X," which should be countersigned by a witness.
8	**Month, Day, Year**	The patient's signature must be dated. The waiting period is calculated from this date.
9	**Ethnic Designation**	This information is voluntary and should be completed only by the patient.
10	**Language**	Indicate the language in which the patient was counseled, if other than English.
11	**Interpreter's Signature**	Must be signed if an interpreter was used.
12	**Month, Day, Year**	Interpreter's signature must be dated.

Ref. No.	Blank	Instructions
13	**Name of Individual**	Enter the patient's name here.
14	**Name of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation must be written out at the bottom of the form.
15	**Person Obtaining Consent**	The person providing sterilization counseling may be a physician or the physician's designee (e.g., an office nurse). Once this section is completed, the patient should be given a copy of the form.
16	**Month, Day, Year**	Signature of the person obtaining consent must be dated.
17	**Facility**	May be prestamped
18	**Address**	May be prestamped.
20	**Date of Operation**	Enter the date of the operation.
21	**Type of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form. Consent is not invalidated if the operation actually performed differs from the method of sterilization originally planned.
22-23	**Final Paragraphs**	Cross-out the paragraph **not** used. The minimum waiting period is 30 days from the date consent was given, except in cases of premature delivery or emergency abdominal surgery.
24	**Premature Delivery**	If this box is checked, a date of expected delivery must be present in Item 25.
25	**Individual's Expected Date of Delivery**	Date estimated by the physician based on the patient's history and physical condition.
26	**Emergency Abdominal Surgery**	Indicate the operation performed.

Ref. No.	Blank	Instructions
27	**Physician Signature**	Must be completed **after** the sterilization operation, by the physician who has verified consent and who actually performs the operation. The purpose of obtaining consent "shortly before" the operation is to reaffirm consent. This may be done while the patient is in labor or after delivery. In this context, "shortly before" means up to 72 hours prior to the operation.
28	**Month, Day, Year**	Physician's signature must be dated.

Use of the Consent Form

The consent form must be signed and dated by the following:

- The individual to be sterilized;
- The interpreter, if one is provided;
- The individual who obtains the consent; and
- The physician who will perform the sterilization procedure.

The person securing consent shall certify by signing the consent form that he or she:

- Advised the individual to be sterilized, before the individual to be sterilized signed the consent form, that no federal benefits may be withheld or withdrawn because of the decision not be sterilized;
- Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the consent form and in regulations; and
- Determined to the best of his or her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The physician performing the sterilization shall certify by signing the consent form that:

- The physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For Medicaid purposes, the phase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.);

- The physician explained orally the requirements for informed consent as set forth on the consent form;
- To the best of the physician's knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized; and
- At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:
    - Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he or she intended to be sterilized; that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the consent form; and
    - Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the **expected** date of the delivery. The physician shall state the expected date of the delivery on the consent form. At least 72 hours have passed after written informed consent to be sterilized was given.

The interpreter, if one is provided, shall certify that he or she:

- Transmitted the information and advice presented orally to the individual to be sterilized;
- Read the consent form and explained its contents to the individual to be sterilized; and
- Determined to the best of his or her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual.

A copy of the signed consent form must be:

- Provided to the patient;
- Retained by the physician and the hospital in the patient's medical records; and
- Attached to all claims for sterilization services. In addition, no sterilization procedure will be covered at all by Virginia Medicaid unless a copy of the Department of Medical Assistance Services Consent Form (DMAS-3004) is attached to the invoice submitted by each provider, including the surgeon, assistant surgeon, anesthesiologist, hospital, or outpatient clinic in order that each claim might be evaluated. **The DMAS-3004 is the only consent form that will be accepted by Medicaid, and no payment will be made without**

submission of this form by each provider involved in the sterilization procedure. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

Claims for Service

Any claim submitted without a properly executed consent form will be denied. The originating physician is required to supply a copy of the DMAS-3004 to other billing providers.

Note: With the implementation of DRG payment methodology effective with admissions on or after January 1, 2000, for labor and delivery the facility can remove all associated charges for the sterilization when a properly executed DMAS-3004 form is not done. Do not include the specific sterilization procedure code on the claim. This will allow payment for the labor and delivery.

ICD-9-CM Sterilization Procedure Codes

624	Bilateral orchidectomy
6241	Removal of both testes at same operative episode
637	Vasectomy and ligation of vas deferens
6370	Male sterilization procedure, not otherwise specified
6371	Ligation of vas deferens
6372	Ligation of spermatic cord
6373	Vasectomy
655	Bilateral oophorectomy
6551	Other removal of both ovaries at same operative episode
6552	Other removal of remaining ovary
6553	Laparoscopic removal of both ovaries at same operative episode
6554	Laparoscopic removal of remaining ovary
656	Bilateral salpingo-oophorectomy
6561	Other removal of both ovaries and tubes at same operative episode

6562	Other removal of remaining ovary and tube
6563	Laparoscopic removal of both ovaries and tubes at same operative episode
6564	Laparoscopic removal of remaining ovary and tube
662	Bilateral endoscopic destruction or occlusion of fallopian tubes
6621	Bilateral endoscopic ligation and crushing of fallopian tubes
6622	Bilateral endoscopic ligation and division of fallopian tubes
6629	Other bilateral endoscopic destruction or occlusion of fallopian tubes
663	Other bilateral destruction or occlusion of fallopian tubes
6631	Other bilateral ligation and crushing of fallopian tubes
6632	Other bilateral ligation and division of fallopian tubes
6639	Other bilateral destruction or occlusion of fallopian tubes
665	Total bilateral salpingectomy
6651	Removal of both fallopian tubes at same operative episode
6652	Removal of remaining fallopian tube
666	Other salpingectomy

Retroactive Coverage

Providers are reminded that sterilization is covered only if all applicable requirements are met for the operation performed. This includes:

- The time period required between the date of informed consent and the date of sterilization;
- The informed consent requirements for the individual to be sterilized; and
- The certification requirements for signatures of the individual to be sterilized, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the DMAS-3004.

If a patient obtains retroactive Medicaid coverage, previously provided sterilization services cannot be billed unless the applicable requirements have been met. There are no exceptions made for retroactive eligibility in regard to the requirements for sterilization.

OTHER UTILIZATION REVIEW ACTIVITIES

Ancillary Services for Denied Hospital Days

Medicaid will accept outpatient billings for the medically necessary ancillary services that would have been rendered on an outpatient basis but are provided during a denied inpatient stay. These outpatient billings are limited to those ancillary services performed for any inpatient denials within the first three days of hospitalization. These billings, for utilization review purposes, are to be sent to:

Manager, Payment Processing Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Every effort must still be made to ensure that ancillary services are performed on an outpatient basis when appropriate.

ClaimCheck

Beginning with claims received on or after July 1, 2001, ClaimCheck will be implemented by DMAS. Claim Check is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS will be utilizing Claim Check as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS will be making the necessary voids or adjustment of claim(s) as a result of the ClaimCheck.

Review and Evaluation
[Effective Date: April 1, 1990]

DMAS may exempt, modify, or reapply one or more of the utilization review documentation requirements for claims submitted for specific hospitals as part of its ongoing hospital utilization review performance evaluation. At least once a year, DMAS staff will visit the facility or conduct desk audits to review selected documentation requirements and medical records and to possibly interview the patients. The purpose of the review of the medical records is to evaluate the necessity for and adequacy of the care provided and to audit compliance with state and federal regulations and policies. The provider will make all medical records available as requested for utilization review within the allowed timeframe.

Beginning May 1, 2001, DMAS will begin conducting reviews of medical records for validation of prior authorizations and Diagnosis Related Groups (DRGs) in addition to the annual desk utilization reviews.

In order to validate the prior-authorizations, DMAS Hospital Utilization Review Analysts will review information contained in the patient's medical record with that provided by phone to WVMI during the prior-authorization process. This review is to ensure that the admission for medical/surgical cases and admission and length of stays for psychiatric cases are appropriate based on the patient's medical record. During the review of the DRG validation, DMAS staff will be insuring that the correct diagnosis and procedure codes submitted on the claim are supported in the recipient's medical record. Reimbursement(s) that was provided and found not supported in the medical records either through review of prior-authorization or DRG validation will be retracted.

All reviews will be done on a post payment basis; therefore, the current process of calling WVMI for prior authorization requests does not change. In addition, claims will not suspend pending review of the medical records, and the initial payment of the claims will not be affected.

Provider Appeals

Appeals regarding the medical necessity of admissions, continued stays, outpatient emergency services, and other services are to be heard by the hospital Utilization Review Committee. Appeals concerning the denial of payment by DMAS will be heard by DMAS.

Requests for reconsideration of denied hospital days prior to the hospitals' activation of preauthorization of admission by WVMI or for emergency room services, should be sent with additional supporting documentation to:

Manager, Payment Processing Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-calendar day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting a reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Requests for reconsideration of denied hospital days based on the preauthorization process by DMAS or their designated contractor (WVMI) are as follows.

Reconsideration Process

Providers requesting reconsideration must do so upon verbal notification of denial by DMAS or the designated contractor (WVMI).

This process is available to providers when the nurse reviewer advises the provider by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he or she disagrees with the nurse reviewers' findings. If the higher level of review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

If a higher level of review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept the decision, and the case will be denied, and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he or she must request physician review by DMAS Medical Support. The case remains in suspense and is referred to DMAS Medical Support for the last step of reconsideration.

DMAS Medical Support will review all case-specific medical information. DMAS Medical Support shall have two working days to render a decision. If DMAS Medical Support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

Recipient Appeals

Upon receipt of a denial letter, the recipient shall have the right to appeal an adverse decision if the issue is whether DMAS will reimburse for services **not** yet rendered. Under the client appeals regulation, (12 VAC 30-110-160), the recipient shall have 30 days from the date of the denial letter to file an appeal.

Provider Appeals

If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. This appeal must be in writing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia et seq. and § 32.1-325.1.

DOCUMENTATION GUIDELINES

[Effective Date: September 1, 1989 and until the hospital's activation of preauthorization by WVMI for all inpatient hospital admissions]

The following guidelines are presented to assist in reducing the number of claim denials by DMAS due to missing, inadequate, or inappropriate documentation. These guidelines must be followed for claims that pend for review.

Guidelines for Submission of Documentation

Invoices with the following conditions will pend for review if the dates of service are prior to the activation of the authorization process by WVMI. Documentation must accompany the invoice which will justify each pended condition. These claims edits have been removed for all inpatients hospitalization invoices effective with dates of admission on or after January 1, 2000. The exception is the requirement for the specialty forms (abortion, hysterectomy or sterilization) and the 21 days within a 60-day period as previously indicated for psychiatric services.

Saturday/Saturday Admission

For a length of stay of three days or less, place the justification for admission and treatment provided in Locator 94 of the invoice. There is no need to attach further justification unless this space is not adequate or the claim will be pending for reason(s) requiring specific documentation, such as consent forms.

For a length of stay of four days or more, the history and physical, physician progress notes, and discharge summary are required.

More Than 1 Day Preoperative Admission

The history and physical, physician progress notes, and discharge summary are required.

Continued on Next Page

Length of Stay More Than 7 Days
[Effective: For Dates of Service On and After July 1, 1991]

The history and physical, physician progress notes, and discharge summary are required.

Length of Stay Exceeds Percentile Limit

The history and physical, physician progress notes, and discharge summary are required.

Sterilization, Hysterectomy, and Abortions

The specialty forms for the above-referenced procedures (Sterilization DMAS-3004, Hysterectomy DMAS-3005, and Abortion DMAS-3006), history and physical, physician progress notes, and discharge summary are required. Length of stay requirements must also be met for admission prior to the activation of preauthorization requirements by WVMI. For invoices with authorization by WVMI, the specific form is the only requirement.

Length of Stay 21 Days or Greater Within 60 Days and Recipient Is Under 21 Years of Age

With the first invoice, the history and physical and physician progress notes are required. With all subsequent invoices for continued stays, only the physician progress notes are needed for the continued billing period (the discharge summary is required with the last invoice).

Length of Stay 21 Days or Greater Within 60 Days and Recipient Is Age 21 Years of Age or Older

With the first invoice, the history and physical and physician progress notes are required. There are no documentation requirements for all subsequent invoices of continued stays.

With the implementation of DRG payment methodology (effective for admissions on or after January 1, 2000), this edit remains in effective for recipients receiving psychiatric services.

Surgeries Listed on Mandatory Outpatient Procedures Performed as Inpatient List

The history and physical physician progress notes, and discharge summary are required.

When sending documentation with inpatient claims, be certain that the documentation is attached to the invoice. If the Medicaid utilization review analyst assigned to the hospital

requires additional documentation, it will be noted on DMAS request. This letter will specify the particular documentation needed and will be sent to the representative designated by each hospital. When responding to the request, return the request letter attached to the documentation. Requested documentation must be received by Medicaid no later than the 20th day from the date of the request letter. If the documentation is not received by the 20th day, the claim will be denied for the reason "Requested Information Not Received." To resubmit these claims, attach the additional documentation to the original invoice along with the original documentation. If the claim was originally submitted on magnetic tape, a paper UB-82 invoice must be completed. Remember that inpatient claims submitted on magnetic tape requiring Abortion, Hysterectomy, or Sterilization Consent forms may be manually submitted with the appropriate form and documentation attached to the invoice.

Note: Where appropriate, detailed and properly completed Utilization Review Summary Worksheets can be used to justify hospital days in lieu of Patient Progress Notes. These worksheets must reflect acute care criteria as being met on a daily basis. Acceptance of these Utilization Review Worksheets will be at the discretion of the Department of Medical Assistance Services Payment Processing Unit.

If there are any questions regarding appropriate documentation to be sent with inpatient hospital claims, contact the Medicaid Provider HELPLINE at 786-6273 (Richmond area) or 1-800-552-8627 (all other areas).

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit in the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy, or both, in the Client Medical Management Program (CMM). (See "Exhibits" at the end of Chapter I for detailed information on the CMM Program.) If CMM enrollment is not indicated, RMU staff may educate recipients in the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

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MEDICAID ADMISSION CERTIFICATION/PLAN OF CARE

HOSPITAL ADMISSION IS CERTIFIED NECESSARY FOR THE FOLLOWING REASON(S):

ESTIMATED PERIOD OF HOSPITALIZATION:

PLAN OF CARE:

PLAN TO DISCHARGE		HOME WITH OFFICE FOLLOW-UP
		HOME WITH HOME HEALTH CARE
		EXTENDED CARE FACILITY
		OTHER (SPECIFY)

PHYSICIAN'S SIGNATURE: DATE:

VIRGINIA MEDICAL ASSISTANCE PROGRAM

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____: My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Island
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter (Signature) Date

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■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

(TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization) _____ (operation) I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____ (Date)
- ☐ Emergency abdominal surgery:
  (describe circumstances): _____

_____
(Signature) Physician
Date _____

ALL APPLICABLE BLANKS MUST BE COMPLETED.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

It has been explained to _____ of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____ _____
(Recipient's or Representative's Signature) (Date)

If Required: _____ _____
(Interpreter's Signature) (Date)

PHYSICIAN STATEMENT

I, Doctor _____, certify that the hysterectomy

performed _____ on _____ of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

(X) MARK THE APPROPRIATE BLOCK

A ☐ was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

B ☐ was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was

_____

_____
(A Description of the Nature of the Emergency)

C ☐ was performed subsequent to the patient being sterile. This judgment is based on the following condition(s): _____

_____

_____ _____
(Physician's Signature) (Date)

(A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO EACH INVOICE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PROVIDERS FOR THEIR USE WHEN BILLING MEDICAID.)

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VIRGINIA MEDICAL ASSISTANCE PROGRAM

ABORTION CERTIFICATION

I, Doctor _____,

certify that on the basis of my professional judgment ☐ the life ☐ the health of

_____ of _____
(Name) (Address)

would be substantially endangered if the fetus was carried to term.

This judgment is based on the following diagnoses and/or conditions:

_____

_____

_____

_____

_____

_____

_____

_____
(Signature)

_____
(Address)

_____

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HOSPITAL COPY